

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6601

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

FILM NO. G 1 JAN 16 1951

1. PLACE OF DEATH COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHESTERTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown Rt. #1 Box #51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne's Hwy Hosp</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MARGARET</u> (First) <u>ANDERSON</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 10, 1877</u> <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Ewingtown, MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>John Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>6709 Rochester, Chestertown</u>	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cardiac Failure</u>		<u>2 weeks</u>	
450.1 Antecedent cause(s) (b) <u>Arteriosclerotic Degeneration - Feet</u>		<u>2 mos.</u>	
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>50</u> , to <u>1/5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>51</u> , and that death occurred at <u>1 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Edgar L. Lane M.D.</u>		ADDRESS <u>Chestertown, Md.</u> DATE SIGNED <u>1/5/51</u>	
23. BURIAL/CREMATION REMOVAL (Specify) <u>Church Hill</u>		DATE THEREOF <u>1/8/51</u> NAME OF CEMETERY OR CREMATORY <u>near Church Hill Md</u> (State)	
DATE REC'D BY LOCAL REG. <u>1-6-51</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> 24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill Md</u>	

220826

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.02

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kentland Queen Anns</u>		STREET ADDRESS (If rural, give location) <u>Cannon</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nellie</u> (Middle) <u>Newman</u> (Last) <u>Blackway</u>	4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 28, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Owner</u>	9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer H. Newman</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Biddson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Herman Blackway, Jr. Chestertown Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute circulatory failure</u>	<u>4 days</u>
Antecedent cause(s) (b) <u>Myocarditis, chronic</u>	<u>10 days</u>
(c) <u>stating the underlying cause last</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to JAN. 8, 1951, that I last saw the deceased alive on JAN. 8, 1951, and that death occurred at 8:45 p.m., from the causes and on the date stated above.

SIGNATURE Ac Sick. W. S. ADDRESS Chestertown, Maryland DATE SIGNED 1-8-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Jan. 10 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>	LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 9-1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells-</u> ADDRESS <u>Chestertown, Md</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED  
JAN 11 1951  
READ V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Same</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u> LENGTH OF STAY (in this place) <u>2 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Flatland Rd.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u> (Middle) <u>William</u> (Last) <u>Capel, Jr.</u>	4. DATE OF DEATH (Month) <u>11</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 29, 1950</u>
9. AGE last birthday <u>1 yr.</u>		10. AGE last birthday <u>1</u> under 1 year <u>24</u> Months <u>24</u> Days <u>24</u> Hours <u>24</u> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George William Capel, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Helma Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>George William Capel (Same)</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1125 Immediate cause  
Antecedent cause(s)  
118 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Asphyxiation  
(b) Prematurity  
(c) Vomiting

INTERVAL BETWEEN ONSET AND DEATH

2 Minutes  
2 mos.  
2 mos.

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

#### 20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. InjURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/29, 1950, to 11/24, 1951, that I last saw the deceased

alive on 1/20, 1951, and that death occurred at 5 AM m., from the causes and on the date stated above.

SIGNATURE Walter E. Ennos, M.D.

(Degree or title)

ADDRESS Chestertown DATE SIGNED 1/24/51

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF Jan. 25 NAME OF CEMETERY OR CREMATORY Crumpton LOCATION (City, town, or county) Crumpton (State) Md.

DATE REC'D BY LOCAL REG. Jan. 24-1951 REGISTRAR'S SIGNATURE Clara S. Barnes 24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.

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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

The correct age

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.  
JAN 28 1951  
FBI



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u> <u>several years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. Pomona</u>		STREET ADDRESS <u>Pomona</u> (If rural, give location) <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Carrie</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Dickerson</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 22, 1882</u>
9. AGE last birthday <u>69</u> yrs.		10. If under 1 year: Months <u>69</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Scheeler</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Emma Slagle - Chestertown R.R.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
447x Immediate cause (a) <u>Heart failure</u>		<u>6 months</u>
Antecedent cause(s) (b) <u>Arterial hypertension + arteriosclerosis</u>		<u>None</u>
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arteriosclerosis</u>		<u>None</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov 15</u> , 19 <u>50</u> , to <u>Jan 26</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>51</u> , and that death occurred at <u>5:30</u> m., from the causes and on the date stated above.		
SIGNATURE <u>Robert T. Farn</u> M.D.		DATE SIGNED <u>Jan 27, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 28, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>
LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>		
DATE REC'D BY LOCAL REG. <u>Jan. 28 - 1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md</u>

MARGIN RESERVED FOR BINDING

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VS. A15





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesdowntown Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesdowntown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>one mi S</u>	
3. NAME OF DECEASED (First) <u>Rachel</u> (Middle) <u>Ann</u> (Last) <u>Graves</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/16/74</u>
9. AGE last birthday <u>76</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Wm. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emmeline Caine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>daughter Mrs Etta Barrett</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion, chronic endo-myocarditis decompensated  
 Antecedent cause(s) (b) arteriosclerosis  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) arthritis

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct, 1950, to Jan 11, 1951, that I last saw the deceased alive on Jan 8, 1951, and that death occurred at 7:00 m., from the causes and on the date stated above.

SIGNATURE A. G. Burgard (Degree or title) M.D. ADDRESS Rockhall, Md DATE SIGNED 1/13/51

23. BURIAL - CREMATION REMOVAL (Specify)		DATE THEREOF <u>Jan. 14 - 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Pomona</u>		LOCATION (City, town, or county) <u>Pomona</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 14 - 1951</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	

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MARGIN RESERVED FOR BINDING

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH- COUNTY <u>Kent</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Queen St.</u>		STREET ADDRESS (If rural give location) <u>Queen sSt.</u>	
3. NAME OF DECEASED (First) <u>Hannah</u>	(Middle) <u>Ellen</u>	(Last) <u>Everett</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 2, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>India</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey Ryckman</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Weston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Mrs. Lula Savington</u>		<u>Chestertown, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coma</u>			Antecedent cause (s) <u>apoplexy, per corditis</u>	<u>1 day</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>None</u>				
OTHER SIGNIFICANT CONDITIONS (c) <u>None</u>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

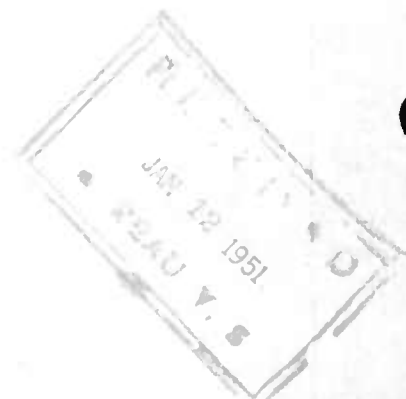
22. I hereby certify that I attended the deceased from....., 19....., to Jan 9, 1951, that I last saw the deceased alive on Jan 9, 1951, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE H. G. Simpson (Degree or title) ADDRESS Chestertown Md DATE SIGNED 1-13-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 12 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Crumpton Cem.</u>	LOCATION (City, town, or county) <u>Crumpton, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan. 10-1951</u>	REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CHESTERTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Greene Anne's Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Prospect St.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>GRIFFIN</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>About 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Not known</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Asbury Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriet ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Emmy Hawkins, RN</u>		<u>Chestertown</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac Failure</u>	<u>3 Mos.</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>	<u>Years</u>
(c) <u>None</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11/28, 1950, to 1/6, 1951, that I last saw the deceased alive on 1/6, 1951, and that death occurred at 12:40 A.M., from the causes and on the date stated above.

SIGNATURE \_\_\_\_\_ (Degree or title) ADDRESS \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

23. BURIAL, CREMATION, REINTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Reinterment</u>	<u>1-8-51</u>	<u>Pomona</u>	<u>Chestertown</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 8-1951</u>	<u>Clara S. Barnes</u>	<u>Edgar L. Lane</u>	<u>Church Hill</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED  
JAN 10 1961  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>337 Cannon St.</u>		STREET ADDRESS (If rural give location) <u>337 Cannon St.</u>	
3. NAME OF DECEASED (First) <u>Lillian</u> (Middle) (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>14</u> (Year) <u>1951</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 18, 1902</u>
9. AGE last birthday <u>48</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife own home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Elizabeth Johnson</u>		<u>337 Cannon St. Chestertown, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Peptic ulcer</u>					
Antecedent cause(s) (b) <u>large decahited ulcer of both lips.</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>multiple sclerosis</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/9</u> , 19 <u>51</u> , to <u>1/14</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>51</u> , and that death occurred at <u>11 45 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Albert G. Burgard M.D.</u>		ADDRESS <u>Rock Hall, Md.</u>		DATE SIGNED <u>1/16/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan. 17, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Quaker Neck (col.) Cem. Pomona Kent County Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 16-1951</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes.</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>	
TOWN <u>Kent and Queen Anne's</u>		TOWN <u>Rural Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Queen Anne's</u>		STREET ADDRESS <u>R.D. 2</u>	
3. NAME OF DECEASED (First) <u>Philip</u> (Middle) <u>Thomas</u> (Last) <u>Jones</u>		4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 9, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil + grocery</u>	9. AGE last birthday <u>57</u> yrs. If under 1 year: Months <u>0</u> Days <u>14</u> Hours <u>19</u> Min. <u>57</u>
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Kent Co - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Purnell T. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Arabella Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>MISSP. RECORDS</u>	
17. INFORMANT AND ADDRESS <u>MISSP. RECORDS</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Generalized carcinomatosis</u>		<u>6 mos</u>
Antecedent cause(s) (b) <u>Carcinoma of pancreas</u>		<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2, 1951, to 1-14, 1951, that I last saw the deceased alive on 1-13, 1951, and that death occurred at 3:25 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>CREMATION</u>	DATE <u>1/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>	LOCATION (City, town, or county) <u>Chestertown, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>JAN. 15-1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hill Rd.</u>	

290636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Millington</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>20 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Kent.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Millington</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>STEPHEN</u> (First) <u>KATONA</u> (Middle) (Last)		4. DATE OF DEATH Jan 2, 1957 (Month) (Day) (Year)		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>6-13-78</u> 9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>Hungary</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MARRIED NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Betty Katona, 180 Dupont St. Phila. Pa.</u>					

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Acute myocardial insufficiency

##### INTERVAL BETWEEN ONSET AND DEATH

can't say

##### Antecedent cause(s)

(b) Chr. Cardio Vascular disease

25 mos

(c) 421.4  
92d  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none none

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE <u>none</u> HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>none</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 2, 1949, to Apr 25, 1950, that I last saw the deceased

alive on Apr 25, 1950, and that death occurred at 1 A.m., from the causes and on the date stated above.

SIGNATURE H. H. Hamilton (Degree or title) M.D. ADDRESS Millington md. DATE SIGNED Jan 2/57

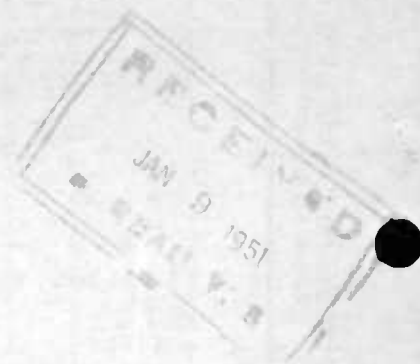
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-5-51</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>		LOCATION (City, town, or county) (State) <u>Chila. Pa.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 3, 1951</u>		REGISTRAR'S SIGNATURE <u>Edward F. Hollows</u>		24. FUNERAL DIRECTOR <u>Edward F. Hollows</u>		ADDRESS <u>Millington md.</u>	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>KENT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN, MD.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>	
TOWN <u>4 days</u>		TOWN <u>BETTERTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne Sea Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr. RICHARD</u>	(First) <u>Krebs</u>	(Middle)	(Last)
4. DATE OF DEATH <u>1/1</u>	(Month)	(Day)	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Oct 17, 1905</u>
9. AGE last birthday <u>45</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Author</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Not known</u>	14. MOTHER'S MAIDEN NAME <u>Germany</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Mrs. Richard Krebs, Betterton</u>	18. MEDICAL CERTIFICATION	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Lobar pneumonia

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1950, to 1/1, 1951, that I last saw the deceased

alive on 1/1, 1951, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 3 - 1951

Clara S. Barnes.

B. R. Fellows Still Pond, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

006899

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

TO: SAC, ALBUQUERQUE (100-100000)

FROM: SAC, DENVER (100-100000)

SUBJECT: [illegible]

[illegible]

[illegible]





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent &amp; Queen Anne general</u>		STREET ADDRESS (If rural, give location) <u>1 mile from Chestertown</u>	
3. NAME OF DECEASED (Type or Print) <u>Addie</u> (First) <u>M</u> (Middle) <u>Morris</u> (Last)		4. DATE OF DEATH <u>Jan 23</u> (Month) (Day) (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <del>SINGLE</del> , <del>MARRIED</del> , <del>WIDOWED</del> , <del>DIVORCED</del> , (Specify)	8. DATE OF BIRTH <u>Oct 6, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Biddle</u>		14. MOTHER'S MARYEN NAME <u>Mary Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Deceased (from hosp. admission)</u>		18. MEDICAL CERTIFICATION	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause  
93d Antecedent cause(s)  
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Congestive heart failure  
(b) Arterial hypertension  
(c)

INTERVAL BETWEEN ONSET AND DEATH

3 weeks  
more than  
4 years

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Obesity

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not While		HOW DID INJURY OCCUR?	
OF INJURY		m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 1-1-57, 19....., to 1-23, 19....., that I last saw the deceased alive on 1-23, 19....., and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE R. B. Barnes (Degree or title) ADDRESS md. Chestertown, Md 1-24-57 DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/26/57</u>	NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	LOCATION (City, town, or county) <u>Church Hill, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan. 25-1957</u>	REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>

72.0826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Xent</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Xent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Maple Ave.</u>				STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MARIA</u>		(First) <u>Bedford</u>		(Last) <u>Power</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Devn home</u>		8. DATE OF BIRTH <u>Feb. 3-1867</u>	
13. FATHER'S NAME <u>John C. Hackett</u>		14. MOTHER'S MAIDEN NAME <u>Cephele Woodland Hackett</u>		9. AGE last birthday <u>83</u> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NO</u>		17. INFORMANT <u>MRS. J. FRANK CONNELLY</u>	
				DENTON, MD	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ComaAntecedent cause(s) (b) 830a central hemorrhageDiseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last (c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		<u>Chestertown</u>		<u>Xent</u>		<u>MD</u>	

22. I hereby certify that I attended the deceased from Jan 5, 1951, to Jan 5, 1951; that I last saw the deceasedalive on Jan 5, 1951; and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>BURIAL</u>		<u>JAN 7 1951</u>		<u>SUDLERSVILLE CEM.</u>		<u>SUDLERSVILLE</u>		<u>MD</u>	

DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 6 - 1951</u>		<u>Claudia S. Barnes</u>		<u>J. Willis Wells</u>		<u>Chestertown, MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

0614

1. PLACE OF DEATH- COUNTY <u>Kent</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>M.D.</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rt. #2</u>	
TOWN <u>Chestertown</u>		TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne's Gen. Hosp.</u>		STREET ADDRESS <u>Shed Oak Farm</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>BABY RINGOLD</u>		<u>1 21 1951</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1/17/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>5</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Samuel Ringold</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Nickerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Samuel Ringold - same</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Hematemesis  
(b) Asphyxia from Aspiration  
(c) Dehydration

INTERVAL BETWEEN ONSET AND DEATH

12 hours

minutes

4 days

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/17, 1951, to 1/21, 1951, that I last saw the deceased

alive on 1/21, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE Robert E. Enos, M.D. ADDRESS Chestertown DATE SIGNED 1/24/51

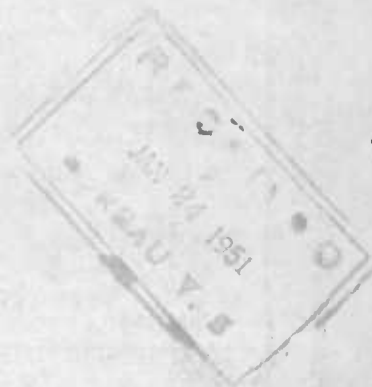
23. BURIAL-CREATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Jan. 22-1951</u>	<u>1/22/51</u>	<u>Big Woods</u>	<u>Near Coleman's Grove, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 22-1951</u>	<u>Clara S. Barnes</u>	<u>Edgar L. Lane</u>	<u>Church Hill, Md.</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.02

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bellerton</u>	
TOWN <u>Chesertown, Md.</u>		TOWN <u>Bellerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent &amp; Queen Anne Sts. Hogg</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr. IRVIN</u>	(First) <u>IRVIN</u>	(Middle) <u>ROBINSON</u>	(Last) <u>ROBINSON</u>
4. DATE OF DEATH <u>1/2/51</u>	(Month) <u>1</u>	(Day) <u>2</u>	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Nov. 5, 1876</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months <u>80</u>	If under 24 hrs. Days <u>80</u> Hours <u>80</u> Min. <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Warwick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>242 Charles Jacobs Chesertown</u>	
17. INFORMANT AND ADDRESS <u>242 Charles Jacobs Chesertown</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Cardiac Failure

##### Antecedent cause(s)

(b) Generalized arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 Days

Years

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

##### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY? Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 5, 1951, to Jan. 7, 1951, that I last saw the deceased

alive on Jan. 7, 1951, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

##### 23. BURIAL CREMATION

(Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 8-1951

Clara S. Barnes

B. R. Fellows

Still Pond, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Massey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Massey</u>	
TOWN <u>Massey</u>		TOWN <u>Massey</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>AMELIA</u> (Middle) <u>SHELTON</u> (Last) <u>SHELTON</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 14 1861</u>
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Valentine Shelton</u>		14. MOTHER'S M maiden name <u>Sallie Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Rudy Everett Massey md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Thrombosis</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>Senile arterio-sclerotic Cardio Vascular Disease</u>		<u>5 years</u>
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 1951, to Jan 28, 1951, that I last saw the deceased alive on Jan 27, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE <u>Richard W. Compton</u>	DATE <u>Jan 30 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Massey Cem.</u>	LOCATION (City, town, or county) <u>Massey md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 29 1951</u>	REGISTRAR'S SIGNATURE <u>Edward Bellows</u>	24. FEDERAL DIRECTOR <u>Edward Bellows</u>	ADDRESS <u>Willington md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH COUNTY <u>West</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>West</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall or R.R.</u> LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall R.R.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>		STREET ADDRESS (If rural, give location) <u>Sharpsburg</u>	
3. NAME OF DECEASED (First) <u>Walter</u> (Middle) <u>Leroy</u> (Last) <u>Nisco</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>11</u> (Year) <u>1941</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 8-1937</u>
9. AGE last birthday <u>13</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Rock Hall R.R. 3rd</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel R. Nisco</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Samuel Nisco - Rock Hall</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Convulsions - sudden death.</u>		
(b) Antecedent cause(s) <u>Epileptic of 8 years duration</u>		
(c) <u>Sent to John Hopkins Clinica for 8 years</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Age 13 caught - 22.10. Obesity.</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Medical Attention, 19....., that I last saw the deceased alive on April 11, 1941, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE <u>Frank H. Smith</u>	(Degree or title) <u>Deputy Medical Examiner</u>	DATE SIGNED <u>Jan 13/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Jan 14-1950</u>	NAME OF CEMETERY OR CREMATORY <u>Sharpsburg</u>	LOCATION (City, town, or county) (State) <u>Rock Hall West Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 13/51</u>	REGISTRAR'S SIGNATURE <u>J. Woodruff</u>	24. FUNERAL DIRECTOR <u>Marvin Williams</u> ADDRESS <u>Chesapeake Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.02

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural (pomona)</u> LENGTH OF STAY (in this place) <u>several years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pomona near Chestertown, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>near Chestertown, Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas</u> <u>Rose</u> <u>Starr</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 24, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 17, 1867</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Fulton Co. Penna</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcus Starr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mellott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Russell Starr- Chestertown, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>		
Antecedent cause(s) (b) <u>chronic Endocarditis, Myocarditis, arteriosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arteriosclerosis</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20, 1957, to 1/24, 1951, that I last saw the deceased alive on 1/24, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>	LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 27-1951</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes.</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells-</u>	ADDRESS <u>Chestertown, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

501817





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH - COUNTY <u>Stent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Rural Horton Kent. md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Horton md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colemans. Horton. md.</u>	
TOWN <u>Rural Horton md</u>		TOWN <u>Colemans. Horton. md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Reese</u> (Middle) <u>Clifton</u> (Last) <u>Walley</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov 7 / 1899</u>
9. AGE last birthday <u>51</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Classroom work labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Classroom work</u>	11. BIRTHPLACE (State or foreign country) <u>Rural Horton md.</u>
13. FATHER'S NAME <u>Walter Walley</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Rokhoda Livers Horton Rural md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) Bronchial Asthma

#### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) nephritis

### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION

### 19b. MAJOR FINDINGS OF OPERATION

### 20. AUTOPSY?

Yes ☐ No ☐

### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1951, to Jan 17, 1951, that I last saw the deceased alive on Jan 17, 1951, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

### 23. BURIAL, CREMATION REMOVAL (Specify)

### DATE THEREOF

### NAME OF CEMETERY OR CREMATORY

### LOCATION (City, town, or county)

### (State)

DATE REC'D BY LOCAL REG. 1/20/51 PM

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

820105

RECEIVED BY MAIL, 1951

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C. 20250

1951



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1620 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ches Kent town</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ches Kent town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne Hospital</u>		STREET ADDRESS (If rural, give location) <u>Chester town, Maryland</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Henry</u> (Last) <u>Whittington</u>	4. DATE OF DEATH	(Month) <u>9</u> (Day) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 8 - 1884</u>
9. AGE last birthday <u>66</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Still Pond</u>
12. CITIZEN OF WHAT COUNTRY? <u>Kent</u>	13. FATHER'S NAME <u>James Henry Whittington</u>	14. MOTHER'S MAIDEN NAME <u>Charlotte Tilla Downes</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4221 Immediate cause (a) <u>Peripheral circulatory collapse</u>		<u>24 hours</u>
462 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Myocarditis, arteriosclerosis.</u>		<u>Years</u>
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized carcinomatous due to cancer of the colon</u>		
19a. DATE OF OPERATION <u>1-4-57</u>	19b. MAJOR FINDINGS OF OPERATION <u>Intestinal destruction due to carcinoma of the colon.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4, 1957, to Jan 9, 1957, that I last saw the deceased alive on Jan 9, 1957, and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE Ed Dick ADDRESS Ches Kent town, Md DATE SIGNED 1-9-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-13-57</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	LOCATION (City, town, or county) <u>Still Pond, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 12 1957</u>	REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	24. FUNERAL DIRECTOR <u>B. R. Fellows</u>	ADDRESS <u>Still Pond, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FILED  
JAN 15 1951  
REAR V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Betherton</u> LENGTH OF STAY (in this place) <u>15 days</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laure de Grace</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>FANNIE</u>	(Middle) <u>HOKE</u>	(Last) <u>WILLIAMS</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Housewife</u>	8. DATE OF BIRTH <u>Aug. 25, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>82</u> yrs.
11. FATHER'S NAME <u>Edward R. McConnors</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Lidia Deaver</u>		14. DATE OF DEATH <u>JAN 2 1951</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>D. Watson</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Endocarditis.</u> Antecedent cause(s) (b) <u>High Blood Pressure</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterial Sclerosis.</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 15th</u> , 19 <u>51</u> , to <u>Jan 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>51</u> , and that death occurred at <u>1:30 P.M.</u> m., from the causes and on the date stated above.		
SIGNATURE <u>L. P. Atwell</u> (Degree or title)		DATE SIGNED <u>Still Pond Md.</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>Jan. 6, 1951</u>	<u>Angel Hill Cemetery</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>1/13/51</u>	<u>E. Keenan Jones</u>	<u>B. R. Fellows Still Pond, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in #18 shown on:

MD. G 150 JAN 30 1951

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norton</u> TOWN <u>Rural Norton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>00 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Morton Rural</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norton md</u> TOWN <u>Rural Norton md</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>J</u> (Middle) <u>Thilmore</u> (Last)		4. DATE OF DEATH <u>Jan</u> (Month) <u>17</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unmarried</u>	8. DATE OF BIRTH <u>5 18 66</u>	9. AGE last birthday <u>84</u> yrs.	10. If under 1 year Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Rural Norton md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Thilmore</u>		14. MOTHER'S MAIDEN NAME <u>Maria Tillison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Ida Horsey Norton R.F. 12 md</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Thrombosis of Carotid Artery</u>					
Antecedent cause(s) (b) <u>Tumors</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterial Sclerosis.</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Tumors, benign. Hips and upper legs. (1-30-51 - ams)</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 20, 1950</u> , to <u>Jan 17 1951</u> , that I last saw the deceased alive on <u>Jan 17, 1951</u> , and that death occurred at <u>7 A</u> m., from the causes and on the date stated above. SIGNATURE <u>L. P. Atwell</u> ADDRESS <u>Stee Pond md</u> (Degree or title) DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>1/20/1951</u>		NAME OF CEMETERY OR CREMATORY <u>Colemans</u>	
LOCATION (City, town, or county) <u>Rural Norton Maryland</u>		(State) <u>md</u>			
DATE REC'D BY LOCAL REG. <u>1/20/51 PM</u>		REGISTRAR'S SIGNATURE <u>E. Kennard Jones</u>		24. FUNERAL DIRECTOR <u>B. R. C. Fellows Still Pond md</u>	

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